Unannounced Care Inspection Report
25 January 2017

Drumary House

Type of service: Residential Care Home
Address: Knockmore Road, Derrygonnelly, BT93 6GA
Tel No: 028 6864 1736
Inspector: Laura O'Hanlon

1.0 Summary

An unannounced inspection of Drumary House took place on 25 January 2017 from 10.30 to 16.40.

The inspection sought to assess progress with any issues raised during and since the last care inspection and to determine if the residential care home was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

There were examples of good practice found throughout the inspection in relation staff supervision and appraisal, adult safeguarding, infection prevention and control and risk management.

Seven areas for improvement were identified in relation to staff recruitment and induction practices, fire safety issues, mandatory training and the environment.

Is care effective?

There were examples of good practice found throughout the inspection in relation to care records, audits and reviews, communication between residents, staff and other key stakeholders.

No requirements or recommendations were made in relation to this domain.

Is care compassionate?

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, listening to and valuing residents and taking account of the views of residents.

No requirements or recommendations were made in relation to this domain.

Is the service well led?

There were examples of good practice found throughout the inspection in relation to governance arrangements, management of incidents, quality improvement and maintaining good working relationships.

No requirements or recommendations were made in relation to this domain.

This inspection was underpinned by The Residential Care Homes Regulations (Northern Ireland) 2005 and DHSSPS Residential Care Homes Minimum Standards, August 2011.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	2	5

Details of the Quality Improvement Plan (QIP) within this report were discussed with Deane McMorris, registered manager and Rachel Jones, team manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action did not result from the findings of this inspection.

1.2 Actions/enforcement taken following the most recent care inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the most recent inspection on 3 August 2016.

2.0 Service details

Registered organisation/registered person: Potensial Ltd Neil Wadge	**Registered manager:** Deane McMorris
Person in charge of the home at the time of inspection: Deane McMorris	**Date manager registered:** 2 March 2016
Categories of care: LD - Learning Disability LD (E) – Learning disability – over 65 years	**Number of registered places:** 17

3.0 Methods/processes

Prior to inspection we analysed the following records: the previous inspection report, the returned quality improvement plan and the accident and incident notifications.

During the inspection the inspector met with three residents, one member of the domestic staff, three members of the care staff and the registered manager.

The following records were examined during the inspection:

- Staff duty rota
- Three induction programmes for new staff
- Staff supervision and annual appraisal schedules
- Two staff competency and capability assessments
- Staff training schedule/records
- Three staff recruitment files
- Three resident's care files
- The home's Statement of Purpose
- Minutes of recent staff meetings
- Audits of accidents and incidents, health and safety and the environment

- Accident/incident/notifiable events register
- Minutes of recent residents' meetings
- Monthly monitoring report
- Fire safety risk assessment
- Fire drill records
- Maintenance of fire-fighting equipment, alarm system, emergency lighting, fire doors, etc
- Policies and procedures manual

A total of 10 questionnaires were provided for distribution to residents, their representatives and staff for completion and return to RQIA.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 3 August 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector.

4.2 Review of requirements and recommendations from the last care inspection dated 3 August 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 20 (1) (c) (i) **Stated:** First time **To be completed by:** 3 September 2016	The registered provider must ensure that staff appraisals are completed annually.	**Met**
	Action taken as confirmed during the inspection: A review of the schedule for staff appraisals confirmed that staff appraisals were completed annually.	
Requirement 2 **Ref**: Regulation 20 (3) **Stated:** First time **To be completed by:** 3 September 2016	The registered provider must ensure that competency and capability assessments are competed for any staff member who is given the responsibility of being in charge of the home in the manager's absence.	**Met**
	Action taken as confirmed during the inspection: A review of two staff competency and capability assessments confirmed these were completed for any staff member who is given the responsibility of being in charge of the home in the manager's absence.	

Requirement 3 **Ref:** Regulation 27 (2) (t) **Stated:** First time **To be completed by:** 3 September 2016	The registered provider must ensure that all radiators / hot surfaces are individually risk assessed in accordance with current safety guidelines and that subsequent appropriate action is taken.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and review of records confirmed that risk assessments were completed for all radiators / hot surfaces and action taken accordingly.	
Requirement 4 **Ref:** Regulation 27 (4) (d) (v) **Stated:** First time **To be completed by:** 4 August 2016	The registered provider must ensure that the fire safety checks are consistently undertaken and recorded.	**Not Met**
	Action taken as confirmed during the inspection: A review of the record of the fire safety checks identified that there were gaps in the weekly checks in September, October and December 2016. In addition there were no monthly checks recorded for December 2016. This requirement will be stated for the second time.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 21.5 **Stated:** First time **To be completed by:** 3 November 2016	The registered provider should review the adult safeguarding policy to ensure it reflects the current regional guidance including the implementation of a safeguarding champion.	**Met**
	Action taken as confirmed during the inspection: A review of the adult safeguarding policy confirmed that it reflected the current regional guidance. A safeguarding champion has been established in the home.	
Recommendation 2 **Ref**: Standard 23.3 **Stated:** First time **To be completed by:** 15 September 2016	The registered provider should ensure that staff undertake mandatory adult safeguarding training on an annual basis.	**Partially Met**
	Action taken as confirmed during the inspection: A review of the training matrix identified that 9 out of 18 staff had completed the mandatory adult safeguarding training annually. This recommendation will be stated for the second time.	

4.3 Is care safe?

The registered manager confirmed the staffing levels for the home and that these were subject to regular review to ensure the assessed needs of the residents were met. No concerns were raised regarding staffing levels during discussion with residents and staff.

A review of the duty roster confirmed that it accurately reflected the staff working within the home.

Discussion with the registered manager and staff evidenced that an induction programme was in place for all staff, relevant to their specific roles and responsibilities. Three induction records were reviewed during the inspection. The induction booklet was found to be detailed and comprehensive. It was noted that one induction record which commenced on the 12 October 2016 was only partially completed. A recommendation was made to ensure that induction programmes are completed and recorded in a timely manner.

Discussion with staff confirmed that mandatory training, supervision and appraisal of staff was regularly provided. A schedule for mandatory training, annual staff appraisals and staff supervision was maintained and was reviewed during the inspection.

The registered manager and staff confirmed that competency and capability assessments were undertaken for any person who is given the responsibility of being in charge of the home for any period in the absence of the manager; records of competency and capability assessments were retained. A review of two completed staff competency and capability assessments found this to be satisfactory.

Three staff recruitment files were reviewed as part of the inspection process. It was noted in two staff files that only one written reference was received and this was not from the applicant's most recent employer. A requirement was made in this regard.

Enhanced AccessNI disclosures were viewed by the registered manager for all staff prior to the commencement of employment. However it was noted that the date which the Enhanced AccessNI disclosure was returned was not consistently recorded. A recommendation was made in this regard.

Arrangements were in place to monitor the registration status of staff with their professional body.

The adult safeguarding policy and procedure in place was consistent with the current regional guidance and included definitions of abuse, types of abuse and indicators, onward referral arrangements, contact information and documentation to be completed. A safeguarding champion has been established.

Staff were knowledgeable and had a good understanding of adult safeguarding principles. They were also aware of their obligations in relation to raising concerns about poor practice and whistleblowing. A review of staff training records confirmed that mandatory adult safeguarding training was provided for all staff however this was only completed by half of the staff team. This recommendation was stated for the second time.

Discussion with the registered manager, review of accident and incidents notifications, care records and complaints records confirmed that all suspected, alleged or actual incidents of

abuse were fully and promptly referred to the relevant persons and agencies for investigation in accordance with procedures and legislation; written records were retained.

The registered manager confirmed there were risk management procedures in place relating to the safety of individual residents. Discussion with the registered manager identified that the home did not accommodate any individuals whose assessed needs could not be met. Review of care records identified that individual care needs assessments and risk assessments were obtained prior to admission.

The registered manager confirmed there were restrictive practices employed within the home, notably a locked front door and the use of sensor mats. Discussion with the registered manager regarding such restrictions confirmed these were appropriately assessed, documented, minimised and reviewed with the involvement of the multi-professional team, as required.

A review of the statement of purpose and residents guide identified that restrictions were adequately described.

The registered manager confirmed there were risk management policy and procedures in place. Discussion with the registered manager and review of the home's policy and procedures relating to safe and healthy working practices confirmed that these were appropriately maintained and reviewed regularly for example COSHH and fire safety.

The registered manager confirmed that equipment and medical devices in use in the home were well maintained and regularly serviced. Observation of equipment during the inspection validated this.

There was an infection prevention and control (IPC) policy and procedure in place. Inspection of the premises confirmed that there were wash hand basins, adequate supplies of liquid soap, alcohol hand gels and disposable towels wherever care was delivered. Observation of staff practice identified that staff adhered to IPC procedures.

Good standards of hand hygiene were observed to be promoted within the home among residents, staff and visitors. Notices promoting good hand hygiene were displayed in bathroom areas.

The registered manager reported that there had been no outbreaks of infection within the last year. Any outbreak would be managed in accordance with the home's policy and procedures, reported to the Public Health Agency, the trust and RQIA with appropriate records retained.

A general inspection of the home was undertaken and the residents' bedrooms were found to be personalised with photographs, memorabilia and personal items. The home was mostly fresh smelling, clean and appropriately heated. An odour was identified in one bedroom, areas of rust were observed on two radiators and the kicker board in the kitchen was in need of repair. A recommendation was made to ensure these areas were addressed.

Inspection of the internal and external environment identified that the home and grounds were kept tidy, safe, suitable for and accessible to residents, staff and visitors. There were no obvious hazards to the health and safety of residents, visitors or staff. Discussion with the registered manager confirmed that risk assessments and action plans were in place to reduce risk where possible.

The home had an up to date fire risk assessment in place dated 16 November 2016. Whilst the registered manager reported that all recommendations from the fire risk assessment were

addressed they were not appropriately signed off. A recommendation was made to ensure that any actions identified in the fire risk assessment are signed off when completed.

Review of staff training records confirmed that staff completed fire safety training twice was completed by 12 staff in November 2016. Fire drills were completed every six months. Records were retained of staff who participated and any learning outcomes.

A review of the record of the fire safety checks identified that there were gaps in the weekly checks in September, October and December 2016. In addition there were no monthly checks recorded for December 2016. This requirement will be stated for the second time.

Areas for improvement

Seven areas for improvement were identified in relation to staff recruitment and induction practices, firs safety issues, mandatory training and the environment.

Number of requirements	2	**Number of recommendations**	5

4.4 Is care effective?

Discussion with the registered manager established that staff in the home responded appropriately to and met the assessed needs of the residents.

A review of three care records confirmed that these were maintained in line with the legislation and standards. They included an up to date assessment of needs, life history, risk assessments, care plans and a regular statement of health and well-being of the resident. Care needs assessment and risk assessments were reviewed and updated on a regular basis or as changes occurred.

The care records also reflected the multi-professional input into the residents' health and social care needs and were found to be updated regularly to reflect the changing needs of the individual residents. Residents and/or their representatives were encouraged and enabled to be involved in the assessment, care planning and review process, where appropriate. Care records reviewed were observed to be signed by the resident and/or their representative.

Records were stored safely and securely in line with data protection.

The registered manager confirmed that there were arrangements in place to monitor, audit and review the effectiveness and quality of care delivered to residents at appropriate intervals. Audits of accidents and incidents, health and safety and the environment were available for inspection and evidenced that any actions identified for improvement were incorporated into practice.

The registered manager confirmed that systems were in place to ensure effective communication with residents, their representatives and other key stakeholders. These included pre-admission information, multi-professional team reviews, residents' meetings, staff meetings and staff shift handovers. The registered manager and staff confirmed that management operated an open door policy in regard to communication within the home.

Residents spoken with, review of care records and observation of practice evidenced that staff were able to communicate effectively with residents, their representatives and other key stakeholders.

Minutes of resident and/or their representative meetings were reviewed during the inspection.

A review of care records, along with accident and incident reports, confirmed that referral to other healthcare professionals was timely and responsive to the needs of the residents.

Areas for improvement

No areas for improvement were identified during the inspection in relation to this domain.

Number of requirements	0	**Number of recommendations**	0

4.5 Is care compassionate?

The registered manager confirmed that staff in the home promoted a culture and ethos that supported the values of dignity and respect, independence, rights, equality and diversity, choice and consent of residents.

Discussion with staff and review of care records confirmed that residents' spiritual and cultural needs, including preferences for end of life care, were met within the home. The staff shared information about a recent bereavement in the home. They talked about the support provided to the family members and the other residents at the home. The residents were supported to visit the deceased and attend the funeral.

Discussion with residents and staff confirmed that action was taken to manage any pain and discomfort in a timely and appropriate manner. This was further evidenced by the review of care records for example a care plan was in place for management of pain.

Residents were provided with information, in a format that they could understand which enabled them to make informed decisions regarding their life, care and treatment. Care plans were available in the easy read format.

The registered manager and staff confirmed that consent was sought in relation to care and treatment. There was evidence of consent forms contained in care records. Discussion with residents and staff along with observation of care practice and social interactions demonstrated that residents were treated with dignity and respect.

The registered manager and staff confirmed that residents were listened to, valued and communicated with in an appropriate manner. Residents confirmed that their views and opinions were taken into account in all matters affecting them.

Discussion with staff, residents and observation of practice confirmed that residents' needs were recognised and responded to in a prompt and courteous manner by staff.

There were systems in place to ensure that the views and opinions of residents, and or their representatives, were sought and taken into account in all matters affecting them. Such systems included daily discussions, care management reviews, residents' meetings and the monthly monitoring visits.

Discussion with staff, residents and review of care records confirmed that residents were enabled and supported to engage and participate in meaningful activities. Arrangements were in place for residents to maintain links with their friends, families and wider community.

The staff confirmed that family are welcome to visit the home at any time. Care records also reflected ongoing liaison with family members.

One comment made by a resident was:

- "The staff are all very good and kind. The staff keep me informed. I could approach any of the staff or the managers. I like it in here."

Comments made by staff were:

- "There is a choice of meal offered today. We ask the residents and they decide what they want."
- "We have daily schedules in place. The staff are really good to the residents, they are looked after really well."
- "It's getting better, everyone knows what to do and the manager treats us fairly. The management are supportive and approachable. There is sufficient staff in place. I am happy going to my work. The residents all like it in here and there is a good staff team in here."

Areas for improvement

No areas for improvement were identified during the inspection in relation to this domain.

Number of requirements	0	**Number of recommendations**	0

4.6 Is the service well led?

The registered manager outlined the management arrangements and governance systems in place within the home. The needs of residents were met in accordance with the home's statement of purpose and the categories of care for which the home was registered with RQIA.

A range of policies and procedures was in place to guide and inform staff. Policies were centrally indexed and retained in a manner which was easily accessible by staff. Policies and procedures were systematically reviewed every three years or more frequently as changes occurred.

There was an accident/incident/notifiable events policy and procedure in place which included reporting arrangements to RQIA. A review of accidents/incidents/notifiable events confirmed that these were effectively documented and reported to RQIA and other relevant organisations in accordance with the legislation and procedures. A regular audit of accidents and incidents was undertaken and was reviewed as part of the inspection process.

There was a system to ensure medical device alerts, safety bulletins, serious adverse incident alerts and staffing alerts were appropriately reviewed and actioned.

A monthly monitoring visit was undertaken as required under Regulation 29 of The Residential Care Homes Regulations (Northern Ireland) 2005; a report was produced and made available for residents, their representatives, staff, trust representatives and RQIA to read.

There was a clear organisational structure and all staff were aware of their roles, responsibility and accountability. This was outlined in the home's Statement of Purpose and Residents

Guide. Discussion with the registered manager identified that they had understanding of their role and responsibilities under the legislation. The registered manager confirmed that the registered provider was kept informed regarding the day to day running of the home through the monthly monitoring reports.

The registered manager confirmed that the management and control of operations within the home was in accordance with the regulatory framework. Inspection of the premises confirmed that the RQIA certificate of registration was displayed.

The registered manager confirmed that there were effective working relationships with internal and external stakeholders.

The home had a whistleblowing policy and procedure in place and discussion with staff established that they were knowledgeable regarding this. The registered manager confirmed that staff could also access line management to raise concerns they will offer support to staff.

Discussion with staff confirmed that there were good working relationships within the home and that management were responsive to suggestions and/or concerns raised.

The registered manager confirmed that there were arrangements in place for managing identified lack of competency and poor performance for all staff. There were also open and transparent methods of working and effective working relationships with internal and external stakeholders.

Areas for improvement

No areas for improvement were identified during the inspection in relation to this domain.

Number of requirements	0	**Number of recommendations**	0

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Deane McMorris, registered manager and Rachel Jones, team leader, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the residential care home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Residential Care Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and DHSSPS Residential Care Homes Minimum Standards, August 2011. They promote current good practice and if adopted by the registered provider/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to care.team@rqia.org.uk for assessment by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements

Requirement 1 **Ref:** Regulation 27 (4) (d) (v) **Stated:** Second time **To be completed by:** 26 January 2017	The registered provider must ensure that the fire safety checks are consistently undertaken and recorded.
	Response by registered provider detailing the actions taken: Since the inspection held on the 10th August 2016 weekly fire safety checks have been sceduled into the homes daily dairy every sunday and two staff are allocated to undertake the checks and to record when theses checks have taken place onto the fires safety monitoring sheet. The Registered Manager or the Team manager will undertake a monthly fire safety check as part of the services quality assurance process and record when these check have taken place. Additionally the fire safety records will be audited every quarter by an area manager from a different area using the Poten`s Quality Assurance tool. Completed on the 26th Jan 17. It was noted on the inspection report that there were a number of gaps in the weekly checks for September, October & November and no monthly checks for December. Having examined our records there was one weekly check ommitted in September, October and December the weekly checks were scheduled into the dairy but unfortunately the responsibile staff member was on annual leave and the checks where resceduled for the following week. The ommited date in October was conducted by Lakeland Electricial Service and was conducted on the 24-10-16. The December weekly check which was ommitted was sceduled for the 25th December and therefore was not conducted due to Christmas day. The check was resceduled for the following week. The ommitted monthly check in December was completed on the 5-12-16 and was located in the fire safety file for December 16. Due to a clerical error the date read as the 5/1/16 when it actually was completed on the 5/12/16. To support this the monthly check for January 2016 was in place dated 6/1/16
Requirement 2 **Ref:** Regulation 19 (2) **Stated:** First time **To be completed by:** 26 January 2017	The registered provider must ensure that before making an offer of employment, two written references are obtained, one of which is from the applicant's present or most recent employer.
	Response by registered provider detailing the actions taken: A full audit of all staff files has been undertaken using the Potens staff audit tool and all staff have two written references on file , one of which is from the staff members most recent employer. A recruitment check list has also been introducted to ensure that all future staff members have all the legal docuements present before commencement of employment. Additionally the staff files will be audited by every quarter by an area manager from a different area using the Poten`s Quality Assurance tool. The service has employed an administration assistant who will manage and support the managers with the recruitment and selection process. Completed on the 26th Jan 17. It was noted in the inspection report that two staff files examined only

	contained one written referece. There was evidence within the file that all referees where contacted and that a written request for a reference had taken place. Both staff members were employed as bank workers and both are in full time employment with other agencies. One staff member was going through the induction process and was on shift shadowing other staff members and at no point was this staff member lone working. This staff member was not sceduled to lone work until a reference was received. References for both staff have now been received.
Recommendations	
Recommendation 1 **Ref**: Standard 23.3 **Stated:** Second time **To be completed by:** 28 February 2017	The registered provider should ensure that staff undertake mandatory adult safeguarding training on an annual basis.
	Response by registered provider detailing the actions taken: All staff have been reminded of their responsibility towards completion of their mandatory adult safeguarding training via the on line e-learning course on CPL. The Senior Support Worker will work along side staff to ensure that each staff member has sufficient time at work to complete their e-learning. The Registered Manager is also looking at providing additional face to face training to cover the specific procedures relating to Northern Ireland. All staff have signed up to the safe guarding adults pledges. Completed on the 28th February 2017 The inspection report stated that 9 staff had not undertaken their safeguarding adults training. Four of these staff where new employees and therefore currently undergoing their induction process and would be required to undertake their e-learning within a three month period. Dates have been scedule for these staff to complete their e-learning. 3 existing staff have completed their safe guarding adults training on the the 27th Jan and the remaining staff within the next month. On the 1st June 2016 the Safeguarding lead within the Western Trust undertook a breifing session with all staff outlining the new policy and procedures and staff responsibility towards Safeguarding.
Recommendation 2 **Ref**: Standard 23.1 **Stated:** First time **To be completed by:** 28 February 2017	The registered provider should ensure that induction programmes are completed and recorded in a timely manner.
	Response by registered provider detailing the actions taken: All staff are required to undertake the Potens Induction programme within a three month period and is to be signed off by the line manager and the new staff member being inducted. A full audit of staff inductions has been undertaken and all staff have now completed and signed off their Induction record. Completed on the 10th February 2017 It stated within the inspection report that 3 staff files had been examined and that one staff member had partially completed their induction. This induction was on-going due to the staff member holding a full time contract with another care agency and was working as and when required as a bank staff for our service.

Recommendation 3 **Ref**: Standard 19.2 **Stated:** First time **To be completed by:** 26 January 2017	The registered provider should ensure that the date on which the Enhanced AccessNI disclosure is returned should be recorded in line with best practice.
	Response by registered provider detailing the actions taken: The Caresys on line staffing system has been up-dated and all staff have a DBS number and the date of which it was issued recorded. All staff files have been audited and a copy of the DBS number and the date when it was issued is also recorded within the staff file. A recruitment check list has also been introduced to ensure that all future staff members have all the legal documents present before commencement of employment. Additionally the staff files will be audited by every quarter by an area manager from a different area using the Poten`s Quality Assurance tool. The service has employed an administration assistant who will assist the managers with the recruitment and selection process including applying for Access NI applications. Completed on the 8th Feb 17 The inspection report indicated that Access NI applications were not consistantly recorded. All information regarding all staff Access NI are held on Caresys and NI Direct portal service which indicates when the application was submitted and issues as well as when it was due for renewal. This information Can only be accessed by the Registered Manager and the Team Manager.
Recommendation 4 **Ref**: Standard 27.1 **Stated:** First time **To be completed by:** 28 February 2017	The registered provider should ensure that the following issues are addressed: • Address the malodour in one identified bedroom • Address the areas of rust on two identified radiators • Repair the kicker board in the kitchen.
	Response by registered provider detailing the actions taken: The bedroom which was identified as creating a malodour was not in use as from the 23rd January 2017. The carpet which was creating the odour has now been removed and will be replaced. The bedroom has received a deep clean. The two identified radiators have now had the rust removed and treated before repainting. The Kicker boards in the kitchen area have also been replaced. Completed on the 8th Feb 17
Recommendation 5 **Ref**: Standard 29.1 **Stated:** First time **To be completed by:** 8 February 2017	The registered provider should ensure that any actions identified in the fire risk assessment are signed off when completed.
	Response by registered provider detailing the actions taken: All identified actions within the fire risk assessment have been completed and signed off by the Registered Manager. Completed on the 6th Feb 17.

Please ensure this document is completed in full and returned to** care.team@rqia.org.*uk* **from the authorised email address*

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews